Vol. XXXVIII 1, 4, 5-6 No. 2

ALBANY MEDICAL ANNALS

Journal of the Alumni Association of the
Albany Medical College

FEBRUARY, 1917

Ασφαλὲς καὶ ἔμπεδον ἔστω το σὸν ἦδος. Ἐκ σκότου μὲν ἔξαγε φάος, ἐκ δὲ πάθους ἀναψυχήν.

ALBANY MEDICAL ANNALS

Journal of the Alumni Association of the Albany Medical College

ALUMNI COMMITTEE

A. VANDER VEER, M. D. W. G. TUCKER, M. D. ANDREW MACFARLANE, M. D.

EDITED BY

J. MONTGOMERY MOSHER, M. D.

Published on the First of every month
Subscription Price, Two dollars per annum in advance
Advertising Rates given on Application

Address all communications to ALBANY MEDICAL ANNALS,
170 Washington Avenue, Albany, N. Y.
Entered as Second Class matter at the Post Office, Albany, N. Y.

Vol. XXXVIII, No. 2 CONTENTS FEBRUARY, 1917

ORIGINAL COMMUNICATIONS

EDITORIAL

PUBLIC HEALTH

HOSPITAL AND COLLEGE NOTES

MEDICAL NEWS

CURRENT MEDICAL LITERATURE

REVIEWS AND NOTICES OF BOOKS

NEW YORK STATE MEDICAL LIBRARY

The Library contains 19,460 bound volumes, several thousand pamphlets and unbound periodicals, and receives currently about 500 serials.

Hours of Opening.—Each week day (Christmas, Thanksgiving and Fourth of July excepted) from 9 A. M. to 6 P. M. and on Tuesdays and Thursdays until 10 P. M. from October to May, inclusive.

Loans.—Books may be borrowed by any licensed physician in the State, by full-time instructors on the faculty of any medical college, members of the house staff of any hospital, registered and certified nurses, or any one engaged in medical work or pathological research who offers suitable references and credentials. The borrower shall pay return postage on books loaned outside of Albany, use such care in packing as to guard against injury in transportation, and pay for books lost or damaged.

Length of Loan.—The period of loan is two weeks for periodicals; four weeks for other works.

Physicians coming to the library for special research will find it to their advantage to notify the librarian in advance as to the books or subjects desired and the date of the prospective visit.

Library of Surgeon-General's Office, U. S. A.—Physicians wishing books from this National Medical Library may obtain them for two weeks through this Library by paying express charges both ways.

Gifts.—Gifts of books, periodicals or reprints are earnestly solicited. Even single volumes or odd numbers of periodicals of little value to the owner may help to complete valuable sets.

Publisher's Department

MISSIONARY HOSPITAL WORK IN INDIA.—Qualified medical man required who is in sympathy with religious work. Passage paid and small monthly allowance made. Three years agreement. Apply, sending copies of testimonials. Commander Eva Booth, Field Department, Salvation Army Headquarters, 122 West 14th street, New York City.

Publisher's Department

CHRONIC CARDIAC DISEASE.—The patient with organic heart disease needs constant attention to his digestion and nutrition. A little falling off in the general vitality and the compensatory status of the heart may be lost forever. At the first sign of nutritional decline, therefore, Gray's Glycerine Tonic Comp. should be given. This dependable tonic braces a wavering organism by reinforcing weakened functions. Thus it not only directly contributes to cardiac power, but what is vastly more important, materially reduces the stress under which a feeble heart constantly has to labor. In other words, while increasing the carrying power of the heart, it also decreases the burden.

Publisher's Department

PITUITRIN IN TWO STRENGTHS.—The pituitary extract formerly known as "Pituitrin" and supplied in ampoules will hereafter be designated "Pituitrin O." A second preparation of the pituitary gland, bearing the title of "Pituitrin S," is now announced. Pituitrin S is approximately twice the strength of Pituitrin O. Both products are manufactured by Parke Davis & Co.

Pituitrin O (obstetrical) is intended primarily for use in delayed parturition due to uterine inertia. It has been called "an indispensable item in the armamentarium of the obstetrician."

Pituitrin S (surgical) is indicated specifically in the treatment of post-operative intestinal paresis, vesical atony, hemorrhage, shock, etc. It is of the utmost utility in the hands of the surgeon and internist.

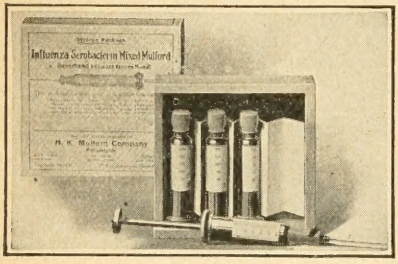
Pituitrin O is supplied in ampoules of 1 mil (1 Cc.) and ½ mil (½ Cc.). Pituitrin S is supplied in ampoules of 1 mil (1 Cc.) only.

TONICS PREFERABLE TO STIMULANTS.—In selecting a tonic it is highly desirable not to mistake stimulation for tonic action. Stimulation means unduly exciting the higher nerve centers, suddenly and often excessively elevating the blood pressure, and providing a quick but evanescent effect which rapidly passes away and is many times more harmful than beneficial. Tonic action means the gradual restoration of functional efficiency—"helping the body to help itself." Thus, Gray's Glycerine Tonic Comp. is a true tonic, with all the advantages and none of the drawbacks of a stimulant. To state it tersely, "Gray's" is an aid and a support to body functions—a genuine prop—not merely a spur or lash.

"An Ounce of Prevention Is Worth a Pound of Cure"

Immunize your patients against Influenza and "Colds" NOW and do not wait until respiratory affections are prevalent.

Influenza Serobacterin Mixed Mulford will give immunity from attacks of "Colds" and influenza to a large percentage of patients suffering with periodic attacks of disease of the respiratory passages caused by the organisms used in preparing the serobacterin.



Supplied in packages containing four aseptic glass syringes.

Syringes contain killed sensitized bacteria as follows:

	Syringe A	Syringe B	Syringe C	Syringe D
B. influenzæ	125	250	500	1000 million
Staphylococcus albus .	125	250	500	1000 million
Staphylococcus aureus	125	250	500	1000 million
Streptococcus	125	250	500	1000 million
Pneumococcus	125	250	500	1000 million
M. catarrhalis (group)	125	250	500	1000 million

Literature describing method of treatment and dosage, together with special educational bulletins for distribution to your patients, sent on request.

MULFORD FOR THE CONSERVATION OF LIFE LABORATORIES

H. K. MULFORD COMPANY

Manufacturing and Biological Chemists

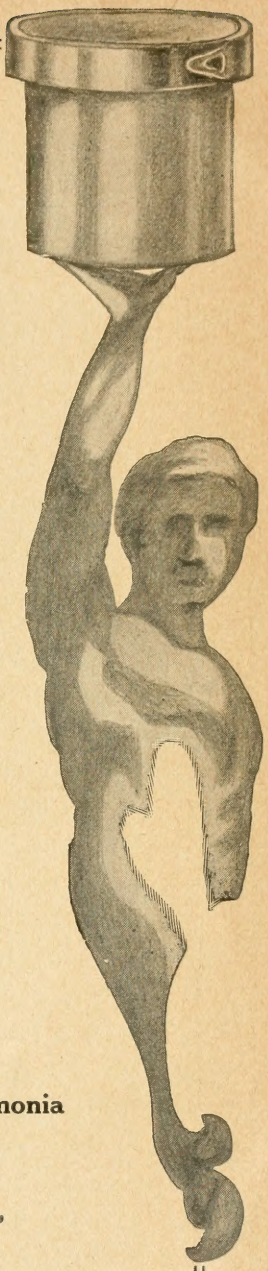
HOME OFFICE AND LABORATORIES

PHILADELPHIA, U. S. A.

21995

MULFORD FOR THE CONSERVATION OF LIFE LABORATORIES

The Fatal Event In Pneumonia



is due either to a gradual toxemia or to a mechanical interference with respiration and circulation. (Osler).

Any medical agent that hastens the elimination of the toxins — that relieves the dyspnoea, cyanosis, and tends to restore normal circulation—is clearly indicated.

ANTIPHLOGISTINE applied hot over the entire chest wall, increases the superficial circulation and by its hygroscopic, depleting and osmotic action, hastens the elimination of toxins. By increasing the capillary circulation the right heart is relieved; the dyspnoea and cyanosis rapidly disappear.

Antiphlogistine
TRADE MARK

A valuable adjunct in the treatment of Pneumonia

SEND FOR PNEUMONIA BOOKLET

"There's Only One Antiphlogistine"

MAIN OFFICE AND LABORATORIES

THE DENVER CHEMICAL MFG. CO., NEW YORK, U. S. A.

Branches: LONDON, SYDNEY, BERLIN, PARIS, BUENOS AIRES, BARCELONA, MONTREAL

Union University

Medical Department

Albany Medical College

Founded 1838

A complete reorganization was effected in 1915. Largely increased hospital facilities were provided with teaching services both in medicine and surgery, students having immediate responsibility under supervision. The laboratory staff has been increased and the courses rearranged to conform to improved methods. With these changes, it is believed that the Albany Medical College is prepared to furnish instruction which will meet the highest demands of modern medical education.

Admission Requirements: Each candidate for admission must present his Medical Student's certificate from the Examination Division of the Board of Regents of the State of New York. In addition to the Regents' certificate the student is also required to show evidence of the satisfactory completion, in a recognized college or scientific school, of at least one year's course of study including French or German, biology, physics and chemistry, or an equivalent. Union College, the academic department of Union University, Schenectady, N. Y., has arranged for such a course.

Tuition: The charge for tuition is $160.00 a year and $5.00 for matriculation. The fee for dissecting material is $15. There are no extra fees except for rental of microscopes and laboratory breakage.

The academic year begins Sept. 25, 1916. All inquiries and other communications should be addressed to Thomas Ordway, M. D., Dean, Albany Medical College, Albany, N. Y.

Publisher's Department

TONGALINE exerts a manifest action on the nervous system of the secreting order of glands, it diminishes the uric acid content of the blood, and produces a substitutive irritation in the region of the articular surfaces. On account of the exaggerated vasomotor action of Tongaline, the irritation drives the poisonous deposits toward the emunctories, causing a great secretion of bile in the liver, an abundant diuresis in the kidneys and a serous diarrhoea in the intestines, while in the feces and in the urine we find a great quantity of uric acid.

These conditions secure the attainment of the desired effect, which is to expel from the organism all those agents, the accumulation and retention of which in the blood are the cause of rheumatism, neuralgia, grippe, gout, nervous headache, malaria, sciatica, lumbago, tonsillitis, heavy colds and excess of uric acid.

A MAN does not see with his eyes or hear with his ears.

He sees and hears with his brain.

He also feels pain—with his brain.

Irritation or stimulation, applied to a sensory or even to a motor nerve, is reflected and transferred to the brain, and pain sensation registered. Much pain is referred to some surface area, e. g., the pain in purlatic disease that is felt in the sole of the foot.

Hence counter-irritation, or even analgesia applied over a surface area which is registering pain—has the effect in most instances of relieving that pain.

It is preferable in many cases to secure analgesia by means of external application instead of giving anodynes per os or hypodermatically.

K-Y Analgesic makes such analgesia attainable.

It is in fact, an anodyne "first-aid."

By virtue of its contained camphor, menthol, and methyl salicylate it is active yet non-irritant. It does not blister, stain the skin or soil the clothing, moreover it is water-soluble, can be easily removed and applied as often as may be found necessary. An especially valuable advantage is that it is greaseless.

Which assures prompt absorption, deep penetration and quick as well as prolonged action and effect.

K-Y Analgesic is intended for the relief of headache, neuralgia, rheumatic pain, soreness or stiffness of muscles or joints, lumbago, sprains, contusions, etc., etc.

It will prove a valuable aid to be used until the doctor can get in touch with his patient or to keep the latter comfortable between his visits. K-Y Analgesic will prove to be a good investment for the doctor to make, it will save him trouble and annoyance, and secure the gratitude of his patients.

VOL. XXXVIII FEBRUARY, 1917 No. 2

ALBANY MEDICAL ANNALS

Original Communications

THE PROBLEM OF THE SOCIAL ADJUSTMENT OF THE UNUSUAL CHILD.

Delivered at a special meeting of the Albany Social Science Society at the Albany Medical College, Albany, N. Y., January 17, 1917.

BY FREDERIC H. KNIGHT, PH.D.,

Superintendent of The New England Home for Little Wanderers.

The problem of the social adjustment of the unusual child comes to us in the form not of a theory but of an actual living human being. It may add to the interest of this discussion if we take a concrete case which we have actually dealt with as an introduction to the more theoretical part of what we may have to say.

On July 7, 1916, Albert Hadway was loafing as was his custom on the street corner in the city in which he lived. He loafed there nearly all day and nearly every day. Occasionally he would shuffle his way home and be fed, but would soon reappear in his accustomed place. When it became dark, if there was no mischief on hand, he would disappear for the night. Let us look at him. He is fifteen years of age, born in a foreign country, but had lived in Bridgeport for the last twelve years. He is a paralytic, never stands erect, walks with a peculiarly awkward and almost repulsive method of those who have been afflicted with that form of paralysis, choreic athetosis. He is shabbily clothed, dirty, utterly lacking in ambition, guilty of petty larceny several times, the butt of all the practical jokes of the wiser boys of the gang and fast becoming a public nuisance. His home is a very poor one. His father had died three years before. The family had been kept together with the assistance of older children, but the income was not adequate and home conditions were bad.

Some hundreds of people that day passed the corner at which this boy was crouching as the hours came and went. It requires no great stretch of imagination to add this statement. Just as several ineffectual people passed the poor fellow who had fallen amongst thieves and had been robbed on his way from Jerusalem to Jericho, so passed by Albert that day a minister, a physician, the judge of the local municipal court, a school teacher, a man very much interested in the psychological study of unusual children, the patrolman on the beat, and a benevolent individual who bore no official relation to the problem. Every one of these good people had a kind thought in his heart and would have been glad to have solved the problem which the appearance of this unfortunate boy presented, but because of the apparent hopelessness of any effort, contented themselves with the kind thought and the sincere wish.

The clergyman might have said, "This poor fellow is evidently on his way to destruction, but he is so confirmed in his bad habits and so repulsive withal, and apparently of such low grade mentally, that mere persuasion would probably fail in his case. He needs a stronger hand than we have."

The school teacher might have said, "I have had a long and dismal experience with this boy already and am at the end of my resources."

The judge might have thought, "Before very long this boy will be before me for trial." "I will try to keep an open mind." He thinks for all that there is just one place for a boy of that type.

The psychologist might have said, "Supposing I had the opportunity of finding out all about this boy, what could I then do by way of treatment?"

The patrolman on the beat says to himself, "I will keep an eye on this boy."

The benevolent individual, if he were of the unwise type, would hand the boy a quarter. If he were a little wiser he would be in despair, but would not hand him the quarter.

Just six months after that date I was speaking at a meeting of a county medical society, a group of about seventy-five or eighty local physicians, on the subject of physical diagnosis

and what could be done if just the problem in hand could be definitely determined. Less than twenty-four hours after that speech, Albert Hadway was put up to our organization. We accepted the boy and in fifteen weeks returned him to his home.

If you should see him now you would see a boy physically and morally upright, well dressed, with regular employment suited to him, giving evidence of a rather high type of self-respect, one who is rather fastidious about his personal appearance, a self-respecting, self-supporting, in every way a desirable member of the community. The clergyman passes him on the street today and bows to him, for he is now in regular attendance upon church services, and is active in the social life of the church. The judge gives him a friendly nod and has no anxious thought regarding him. The school teacher is proud of the fact that the boy was once under her instruction. The patrolman has lost sight of him altogether, the benevolent individual feels that he never put $53.05 to a better use. Home conditions have greatly improved and all is well so far. This, we think, is a good job and what we like to call a hundred per cent job.

In discussing the subject announced, namely, "The Problem of the Social Adjustment of the Unusual Child," we are to speak more particularly of an attempt that is now being made in this direction by an institution in the city of Boston bearing an ancient name which hardly expresses the work the organization is now attempting to do. This institution is The New England Home for Little Wanderers.

In presenting this paper we hope that some contribution will thus be made to the solution of The Problem of the Social Adjustment of the Unusual Child by what may be said by the speaker, and more especially by what may be thought by those who honor me by listening to what I shall say. By social adjustment I mean the fitting of the unusual child to a suitable, permanent environment, or if the process is to be considered I mean the arriving at an exhaustive diagnosis based upon a scientific examination and trained observation tempered by the opinion of an experienced person, followed by such treatment as fits the unusual child for a suitable, permanent environment.

For our present purposes we may divide children coming to the attention of the psychologist or the physician and the social worker into three groups. These groups are obviously not mutually exclusive nor are they exhaustive.

First, those who can be classed as normal, for although this term has wide limits, its use is certainly justified. The normals are those whose physical or mental condition is not such as to tend to social adjustment.

Next, the feeble-minded, those whose mental level is so low as to make certain social maladjustment.

Lastly, by excluding the other two groups we have a certain number who may be called, for want of a better term, unusual. This last is, of course, a composite term, each individual being to a certain extent a type by himself.

Now as we approach the study of this group of unusual children there are certain fundamental principles which may well be kept in mind, remembering that our problem is that of fitting unusual children to a suitable, permanent environment.

First, all queer adults, all grown persons whose efficiency is subnormal because of physical handicaps, all whose conduct is anti-social; in other words, all people who are only partially adjusted to society, those who are apparently not adjusted at all, those of every sort who go to make up the misfits of society, were at one time children, most of whom in early childhood would have exhibited to a skillful observer the beginnings of those traits or defects, physical and mental, whose full fruitage is seen in the maladjustment of adult life.

Second, many of the most significant social virtues are perfectly natural and normal. By the social virtues I mean alertness, a just appreciation of environment, a quick and proper response to changes therein, industry, good nature, fairmindedness, and all other characteristics which make it possible for men and women to live together in peace and comity and to produce in sufficient quantity the natural fruits of civilization.

Third, when for any reason an individual floats poorly in society and fails to contribute his fair share towards society's weal, but does contribute rather more than his fair share to the destructive forces there is always a reason for that condition.

Fourth, if we knew all that might be known about any given individual whose social conduct is unusual and who is the victim of maladjustment, we should be able to trace the whole course of such maladjustment, its beginning, its development and its results and to analyze pretty thoroughly the present picture.

Fifth, in a very gratifying percentage of cases, maladjustment, if not of too long standing or too deeply rooted in personality, may be either wholly remedied or made at least tolerable. In other words, it is not a hopeless task that one sets before him when he attempts to deal with the problem of the unusual individual, especially with the unusual child.

The causes of maladjustment may be physical or mental, or as is quite commonly the case, both physical and mental.

Though progress in many fields of child study has been great, the most notable change in procedure during recent years has been the increased stress put upon accurate diagnosis, and for our purposes tonight diagnosis is the first great word to be emphasized.

Several years ago it dawned upon the speaker that the percentage of failure in dealing with children was alarmingly large. This was true from every standpoint, and more especially from the standpoint of social adjustment. The special group of children which at that time interested me was composed of those whose social conduct was unfavorable for reasons other than that of a low mentality, and I conceived the notion that this group could best be dealt with if it were separated from the group of children whose conduct was unfavorable for many reasons including that of a low mentality. Latterly, I have felt that just that division is rather useless, for in a very large percentage of cases where the dominant cause of maladjustment was apparently not mental deviation, yet mental defect became apparent sooner or later and had to be reckoned with, so that now we deal with unusual children as a group whether their deviation from the normal is occasioned by physical conditions or mental or both. We find in actual experience that this is a much more workable plan. We then found that as a matter of actual practice most methods

thus far employed in dealing with unusual children were analytical. That is, the shreds were unraveled and examined at great length and very properly classified and tagged. Synthesis was, however, almost entirely lacking. Analysis alone without subsequent synthesis does not give a real diagnosis. In other words, having learned of intelligence, heredity, environment and all the rest, who is to assemble all this knowledge and tell us about the whole child? And then inasmuch as our aim is to discharge children one hundred per cent well in every department of the child's being, it is equite essential that someone should be responsible for unity of treatment. The task of synthesising cannot safely be left with any one of a group of enthusiastic specialists working in fields often remote from each other. The fact is that very individual concerned in the processes of analysis usually sees his own work out of proportionate relation to the rest of the task. The psychologist may be very skillful in his special field without knowing very much or caring very much about life beyond the laboratory. The social worker is apt to be led by her sympathies to some doubt of what the psychologist or the pediatrician considers to be cold facts. Again, it seems to me true that children and other patients, but children especially, have been handled at arm's length. The more personal side of the examination and diagnosis was often left and is to this day often left to non-professional and untrained persons. From our standpoint the two elements in a correct diagnosis are thoroughly scientific observation, and the bringing together synthetically of all that is found out by blending scientific examination and thoroughgoing observation so that all the results of the process shall be in the mind of some one responsible person. No one person is sufficient for a complete diagnosis and no one person is sufficient for adequate observation.

Now out of these considerations and many more grew the plan which has already been developed to a considerable extent and which the speaker is trying to carry to a still further development. Under one roof and under one management in a building designed with a special reference to applying the laboratory method to the study of unusual children, we have

our staff of children's specialists on the medical side, our psychologist and psychiatrists, our trained social workers and an arrangement for a twenty-four hour a day supervision in the various departments of child life. A unified diagnosis is made of every child. To this diagnosis contributions are made by the pediatricians, the psychologists, the graduate nurses, the trained social workers, and attendants trained to observe and to report fully and accurately. We have sufficient hospital space with modern equipment for the treatment and care of certain definite physical troubles such as adenoids and tonsils, middle ear, certain functional and other heart troubles, scoliosis, enuresis and especially underweight.

There are many advantages in having as far as possible your whole equipment under one roof and one management. By this means the examiners become expert in the particular problems of the particular organization with which they are connected, and by this means also a consultation of specialists can be personal and not by formal report from one to the other. Though it is not possible that any one person can know all about any one given child, it is possible, and should be accomplished without any great difficulty, for one person to know all that is known of that child, and this person should be experienced in the work and able to receive the reports of various associates and with a judicious mind assemble their findings and make the final diagnosis on which social treatment is to be based. The finest work cannot be done when the child is handled at arm's length. All knowledge should be as nearly first hand as possible, and all that is known should be expressed in language which all interested can understand without frequent recourse to the dictionary. It will not do to speak of a recidivist afflicted with anorexia showing abnormal kinaesthetic sensations and epideixis of attention with a low hyparctic rating, especially if one should add, "You know that no hyparctic rating per se indicates the future possibilities or probabilities of development." It would be much better to speak of an old rounder who had lost his appetite for food and who is numb with cold and who finds it impossible to give his undivided attention to anything, etc. It adds greatly to the interest of

all concerned in making a unified diagnosis of a case not only to understand his own contribution to the diagnosis but to understand the contribution made by everyone else concerned; and after all, the English language is a fairly good medium for the expression of human thought.

It may be well at this point to state again the subject of this paper, which is, "The Social Adjustment of the Unusual Child." Our task has just begun when we have reached our diagnosis. Let us assume that our diagnosis is correct and in its correctness justifies the means used to reach it.

We now know at least in some measure what we have on hand and so far as we have knowledge regarding any given child our knowledge is, let me repeat, accurate. We never completely understand any child. Proper mental tests have been given, a medical examination has been thorough, the scheme of observation has been carried out and we try to write down in a sentence or two our findings; the diagnosis is made.

Now the child is to be adjusted to society, to life in his home, in his neighborhood, in his community and so on in ever-widening circles until fullness of satisfactory life in the world is reached, or at all events until all available means have been exhausted to reach that end. We are now making use of what may be called the social viewpoint. From this viewpoint we may well divide this group of unusual children into three smaller groups.

First, children to whom attention has been called so early in life that by their contact with society the children themselves have not been harmed much nor have they done much harm. These are our most hopeful cases.

The second group is composed usually of older children who have been in contact with society long enough so that the word "misfit" may be applied to them. As yet, however, their condition is not hopeless and their friends not quite discouraged.

The third class is composed of those who are somewhat older still who have deviated from the normal and the desirable in conduct so far that interested parties are thinking only of getting them under cover somewhere where they will do no further

harm to themselves or to friends, but the thought of social adjustment has been well nigh abandoned.

It was to this third class that Albert Hadway, to whom I called your attention at the outset, belonged. So far as we know, there was no one in the city in which this boy lived who had any hope for his future whatsoever. He was unusual, a ne'er-do-well and a misfit, even though he had not passed his sixteenth year. The successful treatment of a boy in the third class, the almost hopeless class, may have more of inspiration and suggestion than the successful treatment of a child, for instance, in the first class; and yet the second and third classes are being constantly recruited because of lack of successful attention to those who in early life are in the first class.

Albert's physical examination showed, as I have indicated, that he was afflicted with choreic athetosis, Romberg's sign was in evidence, the boy's hand grasp was weak, posture faulty in almost every respect; he walked with his toes turned in with a falling gait (festinating) (spastic). You can see the picture.

His case history showed, as I have indicated, that he had been going from bad to worse. He was out of school, out of work, out of everything but mischief, and the mischief was fast becoming very serious. The reform school, or perchance the school for feeble-minded, was just ahead of him.

At the time of his first mental examination his chronological age was 15½ years. His mental age, according to the Binet test, was 10.2 years. His mental age, according to the Yerkes point scale, 10.5, non-English speaking tests having been used. His coefficient of intelligence was 68 per cent.

Let me repeat that he was with us but fifteen weeks and that at the end of fifteen weeks he could stand erect, could walk, run and jump; he had become very much of a gentleman, almost fastidious in his ways. His mental examination at the end of fifteen weeks showed his chronological age as about sixteen years and his coefficient of intellectual ability 94 per cent. Now this does not mean that his actual mentality had changed to the extent that this difference in intellectual ability might indicate. It simply means that the physical apparatus through which his mentality operated had been greatly improved, and if I may use

the term, that he was in better possession of his faculties. But the practical result was the same as it would have been if his actual mentality had increased from 68 per cent to 94 per cent. The environment into which he was adjusted comprised a home whose conditions had been greatly improved by systematic effort on the part of tactful, friendly visitors, an occupation which was suited to him, with sufficient wages to meet all his necessary expenses, including his board, the Young Men's Christian Association with its gymnasium and other helpful influences, a church home of which he is becoming very fond and a sufficient number of congenial friends and companions, and all these influences supplemented by the systematic oversight of a trained social worker.

Up to the present time it would seem that one hundred per cent of that which was needed for the proper development and for the utmost usefulness of this boy had been done. His regime while he was with us consisted of a thorough-going physical examination with necessary blood tests and all, a thorough-going mental examination with a period of observation to assist in the findings, the care of his teeth, the freeing of his ears from cerumen, the testing of his eyes, association with friendly people who had sense as well as friendliness, regular habits of every necessary kind, corrective gymnastics every day in the week excepting Sunday, supplemented with supervised play and with carefully arranged spontaneous play, five meals a day with rest periods between the first and second meals and the fourth and fifth meals. An interesting method of checking up results in securing coordination was in the use of the piano which he loved to play upon. Almost perfect coordination was secured so that the physical defects growing out of his paralysis might easily be passed by without notice by a stranger.

In his case we see very clearly the advantage of having all the equipment necessary under one roof and one management, a good pediatrician who is interested in his task, a skillful and experienced teacher of corrective gymnastics, food well cooked and well served and abundant in quantity, open-air sleeping.

The regime must, of course, be adapted to the special needs of the individual case.

Unusual children are for the most part in the public schools. They are also seen upon public and other playgrounds, in groups upon the street, and they frequently come to the notice of charitable organizations. What a happy day it would be for childhood and for the State if the time could come when every unusual school child has done for it a hundred per cent of all that needs to be done both as to the child's own condition and the conditions under which he must live. While an institution like our own has a very great advantage in doing extensive work, and while it affords almost ideal conditions for the carrying out of regime that is ordered, an institution is not absolutely necessary for the doing of work which is very well worth while.

More than half the battle is won when a correct, exhaustive diagnosis of the whole condition of the child is reached. Then someone must be found who can organize the resources of the community for the remedying of mental and physical defects so far as they may be remedied and for furnishing a suitable environment for each child with proper supervision. In this way an attempt is made at least to do one hundred per cent of the task, and this, at all events, should be the ideal toward which we should strive.

THE BACKWARD CHILD—WHAT CAN BE DONE FOR HIM?

By J. T. KRAUSE, M. D.,

Medical Examiner of Mental Defectives, Board of Education, New York City.

One of the greatest problems before us to-day is that of the child with a limited mentality; psychologists teach us that the period of evolution of intellect reaches its maximum near the age of puberty; during the early years, the mental development is more rapid, becoming lessened in late childhood and finally ceasing at the above stated period. Under normal conditions, this evolution goes on year by year, uninterrupted, with the result that at any given period, the child is referred to as "a normal child for his age." Let us reflect for a moment,—by what standards are we to judge the mental capacity of a child?

As the result of careful studies of thousands of children at different ages, psychologists (Binet, Simon, Kuhlman, Goddard, and others) found that the average normal child had a certain intellectual development at a certain age; this was found to be fairly accurate in children up to the age of nine years; beyond this the variations in the mental development become so great that definite standards could not be established as accurately as for younger children. It remained for Binet and Simon to formulate a series of tests by which the "mental age" or intellectual capacity of each child could be ascertained with a fair degree of accuracy.

It is only natural to suppose that any interference with the mental evolution of a child will result in a lessening of its mental capacity. Let us then consider the factors which, directly or indirectly, influence normal evolution. It is believed that in about sixty to seventy per cent of all cases of feeble-mindedness, some hereditary strain can be traced back to the parents, grandparents, or other antecedents of the child; in other words, there has been an inherited deficiency in the potency of the germ cell; as the result of such deficiency the mental evolution may never materialize, as is illustrated in idiocy, or it may get under way and cease at an early period, as in imbecility; in other cases, the arrested evolution is not as marked as in the types just mentioned, although the mental capacity of the child is much less than that of a normal child at the corresponding age. To this last group belong the so-called "morons," or the highest types of the feeble-minded.

In about thirty per cent of all cases of feeble-mindedness, the histories show that certain toxic or traumatic conditions were directly or indirectly responsible for the permanent damage to the brain. These influences may have acted upon the mother previous to the birth of the child; in other cases, difficulties at birth resulted in injury to the head with a corresponding arrest in mental evolution. Accidents to the child during infancy and certain diseases (spinal meningitis, scarlet fever, pneumonia, etc.,) have left their indelible impressions on the young developing brains; once the damage is done all of these cases of feeble-mindedness seem hopeless in the sense that their brains will

never functionate normally. It is interesting to note that about two per cent of the school population are feeble-minded.

Having considered the various etiological factors which result in permanent damage to the brain with complete or partial arrest of mental development, we now come to a very important group of children known as the dull and backward type. Careful studies have revealed the fact that although there have been no gross pathological changes in the brains, these children, for various reasons, are unable to "keep up" with other children at corresponding ages. As the result of an extensive study of large groups of children in the lower grades of a school system, Goddard found that almost fifteen per cent of the children examined were backward. While there is considerable difference of opinion in regard to the percentage found by Dr. Goddard, I believe his conclusion is a conservative one.

In studying the backward child, carefully we find that certain conditions are present over which he usually has no control. In the large majority of cases, the backwardness can be attributed to these existing conditions. We can all recall how the dullard of the class was made the target for the ridicule of others, but as our knowledge increases, we find in him an object for study and not ridicule.

What are the factors which result in an impairment of normal school progress? Named in the order of importance, we find that the average backward child owes his mental sluggishness to one or more of the following conditions: (a) poor physical condition, (b) poor environment, (c) lack of educational training. It has been my experience that there are a certain number of children in the public schools who are not handicapped by any of the above-named influences, yet they are unable to keep up in the regular grades; they possess a fair amount of "street intelligence," but their records for school work show a lack of proficiency in many subjects. On interviewing the parents of some of these youngsters, a very important fact was revealed: they showed marked evidence of mental inferiority which had probably been transmitted to their children. Of course there are exceptional cases where no etiological factors can be found,

but in about three per cent of all backward children, a decided constitutional inferiority exists in the parents.

We have been taught that any deviation from normal histology of any organ results in a corresponding disturbance in its physiology; we therefore can readily appreciate that any physical condition which will lower the general vitality of a child, will also result in a disturbance in its mental activity. When the blood flowing through the brain is deficient qualitatively or quantitatively, the general nutrition of the brain cells becomes impaired. Not receiving the proper nourishment, how can we expect them to functionate normally? The physical conditions which result in mental sluggishness may be divided into (a) general, and (b) local. The general conditions include diseases which affect the entire body, such as malnutrition, anemia, rickets, etc. Frequently it is found that children are born with a hereditary predisposition to certain constitutional diseases, as tuberculosis, rheumatism, syphilis, etc. In these cases, although mental evolution does not become arrested, certain changes take place in the brain cells, which is evidenced by a general sluggishness in mentality. Where the backwardness has resulted from malnutrition, anemia, or rickets, persistent treatment has resulted in a marked amelioration of the mental condition as well as of the general health.

After examining several thousands of children proposed for the "ungraded classes" in the public schools of New York City, I became convinced that a large percentage of the children examined owed their backwardness to certain local physical defects which were remediable; included in this category are, defective vision, defective hearing, enlarged tonsils, adenoids (defective nasal breathing), diseased teeth, chorea, gastro-intestinal disturbances (auto-intoxication), cardiac disease, etc. As an illustration let us see how defective vision will result in backwardness. Henry Johnson, ten years old, is in a 3A grade; his pedagogical records show that he entered school at six years. His school attendance has been regular; he was in 1A for one term, in 1B for two terms, in 2A for two terms, in 2B for two terms, and in 3A at present; his number work is fair but his reading and spelling are very poor; when the Binet and Simon

tests are applied, he is said to have a "mental age" of eight and one-half years; this makes it appear that Henry is about one and one-half years backward. The physical examination reveals the following: the development and general nutrition are fair; the special senses are normal with the exception that the child shows a marked myopia; aside from this, the physical examination is essentially negative. On entering the classroom, the examiner finds Henry seated in the row next to the last; the teacher has written an example on the blackboard and is explaining it to the pupils. Henry's auditory memory is good, but not good enough to compensate for the deficiency in visual memory; what is the result? the boy failed to grasp a very important point brought out by his teacher; frequent occurrences of this kind not only tend to make the child backward, but results in an indifference on the part of the child; correction of such physical defect is followed by awakened interest and general improvement in mentality. I could cite other instances where the backwardness could be traced directly to certain physical defects which were remediable.

Environment plays a very important rôle during the period of mental evolution. The child brought up amidst pleasant and hygienic home surroundings has a decided advantage over one reared in a crowded and filthy atmosphere. Psychologists have frequently stated that environment has a molding effect on a developing brain. An intense desire to thoroughly understand the backward child, prompted me to visit some of the homes of backward children; in a few cases the home conditions were favorable inasmuch as the child received plenty of food and the sanitary conditions were fair. Where the number of children in the family was small, the child received proper hygiene but where there were five or six youngsters in the family, the child was frequently neglected. In the large majority of families visited the home conditions were poor; the extreme poverty was not only reflected in the children but also in the parents; six, seven, and even eight members of one family occupied three and sometimes four rooms; food and clothing were scarce, and sunshine seemed to be an unknown quantity; three and four children slept in one room and in some instances, the windows were not

only shut, but nailed down tight; is it to be wondered at that these children are in delicate physical conditions with sluggish mentalities? How can mental evolution go on normally when so many detrimental factors are against it? That some of these children are only one and one-half to two years backward seems remarkable. Remove these children from this depressing environment and give them plenty of nourishing food, clothes, and fresh air, and I daresay the results will be gratifying.

In looking over a class of backward children, the examiner finds that a certain percentage are of foreign birth; these children may have been in the country for a short period and as a result, have considerable difficulty with the English language. Frequently when inquiries are made, especially about children of Russian or Italian birth, it is found that they had very little or no schooling abroad. It is very easy to understand what effect the lack of educational training will have in making a child backward. Irregular school attendance is given as another cause of backwardness; this may be brought about by habitual truancy or in cases where the parents move often.

From the foregoing, it can be seen that in the large majority of cases of backward children, some etiological factor can be found which is, directly or indirectly, responsible for the mental sluggishness. Having studied each case carefully and ascertained the cause of backwardness, the question naturally arises, "What can be done for the child?" The answer to a certain extent is obvious. The old principle applied to medicine can also be used here. "Remove the cause, and the effects will partially disappear." The various physical defects found upon examination should receive prompt attention with a view to ultimate correction; careful inquiries should be made regarding the home conditions; as far as is possible, the child should be removed from depressing home influences; the child with an hereditary predisposition to certain constitutional diseases should receive early and vigorous attention. *It is the duty of the physician not only to relieve existing conditions, but to prevent their recurrence;* the underfed child should receive a good nourishing diet and if necessary the assistance of charitable institutions should be enlisted in the child's behalf.

Although the removal of the physical defect or an environmental change will arouse new interest in the child, we must not lose sight of the fact that we are dealing with a child whose mentality has been blunted for a considerable period of time. The pedagogical records show that the child is one, two, or perhaps several years behind in the work done by children of the corresponding age; to place such child in a class with normal children with the idea that he will "catch up" with the other children, would be the height of folly; discouragement and indifference would be the result of such procedure.

Having ascertained the degree of backwardness which is generally indicated by the difference between the mental and chronological ages, our aim should be to find a scholastic environment suitable to the mentality of the child. *It is an established fact that the backward child needs individual attention;* placed in a class with forty or forty-five other children, it is practically impossible for the teacher to give the child all the attention necessary and do justice to the other members of the class. As individual training is essential, it is advisable to place the child with a small group of backward children where special attention can be given to each.

Experience has taught that in order to handle these backward children properly, not more than twelve to fifteen children should be placed in one class. The problem which confronts the teacher of such class is by no means an easy one. Here are several children who, for various reasons, have fallen behind in their work; careful observations show that this backwardness manifests itself in various ways: William Smith, age ten years, has reached the 3A grade but is unable to do the work of that grade; his tonsils and adenoids have been removed and his vision has been corrected; the pedagogical records show that he is not proficient in number work, reading and spelling; he can do 2A number work fairly well and his reading and spelling are about the average 2B; on the other hand, Sam Jones, age eleven years, has reached the 4A grade but is deficient in all subjects; he can do 3A reading and number work, but only 2A spelling. We can readily see that although the degree of backwardness is practically the same in both cases (about two years) nevertheless,

the course of study outlined for the Jones boy cannot be applied to the Smith child.

It is essential that each child be studied *individually;* only after careful observations can the "weak spots" be brought to the surface; having found the deficiency, the curriculum should be adapted accordingly; the improvement which results from this individual training must be gradual and any attempt to make the child "catch up" within a specified time will prove fatal.

Foreign children who become backward as the result of the lack of educational training or difficulty with the English language, should be placed in a so-called "foreign class." It is advisable that children of one nationality be grouped together and an effort should be made to secure a teacher of the same nativity. They should be encouraged to speak the English language and instructed to mingle with American children as much as possible.

When shall the "backward" child return to the grades? No fast rule can be laid down regarding this question; the teacher is to be the sole judge; if, as the result of individual training, the child shows a marked improvement in his work, and when special tests show that his mental age is almost if not up to his chronological age, he shall be placed in a grade on observation; the mental capacity of the child will indicate the proper grade; should he exhibit particular aptitude for the work of that grade within a reasonable period of time, he is no longer to be regarded as a backward child; however, if after repeated efforts he is unable to "keep up" with the class, he may be observed in a lower grade or returned to the special class.

A NEW FIELD FOR RESEARCH.

By T. D. CROTHERS, M. D.,

Hartford, Connecticut

Every thoughtful person recognizes the tremendous importance that is centering about the alcoholic problem. Politically, it is already the subject of intense activity, which is going to increase and become a very large question, that must be answered at the polls to-day and in the future. Voting to abolish

its sale or to license it involve a great many questions which have a medical aspect and must be answered by physicians. Morally, over half of all religious denominations of this country have what is called temperance committees and are waging the most active war against the saloon and the sale of spirits as a beverage. Socially and economically, the positive injury from alcohol is becoming more and more vivid from every statistical study and examination of the facts. Thus, life insurance companies find it a very serious menace to their prosperity. Health boards and health commissions are confronted with the fact, which grows with every new study, that alcohol is a very pronounced and most prominent factor in diseases and degenerations. Up to a recent period, the medical profession have been conservative and more or less indifferent to the influence of alcohol on questions of health and disease. Half a century ago when inebriety was called a disease, the profession united with laymen in bitter criticisms of this so-called fad. Temperance men and temperance workers have been looked down upon as extremists and foolish enthusiasts deserving little or no serious attention, but the subject has grown despite all opposition. A few years ago the quacks forced the profession to recognize the disease side by their claims of cure. A few scientists who were made astonished by laymen undertook to disprove them by exact study of the facts. Curiously enough, they all reached opposite conclusions and some of the leading authorities of Europe and this country have become ardent anti-alcoholics, denying its value, even as a medicine, and condemning its use in every possible way. The laboratories have taken up the study of the effect of alcohol on cell and tissue and have literally revolutionized all previous opinions concerning the stimulant and food value of alcohol. A wealth of facts has opened up in this direction and the modern physician is obliged to give up his previous conception and recognize the teachings of science as a far greater value than opinions and prestiges. The surgeon and clinician must recognize these new studies if he would avoid conflict with advanced scientific teachings and public sentiment. The whole subject will concentrate about the opinions of medical men. They are the final authorities and of all others should

be prepared to give wise counsel. The moral and political side of the subject will, of course, be prominent wherever physicians fail to educate the public, and as a result there will be confusion of theory and practice. The laboratory has shown a wealth of facts concerning the action of alcohol on cell and tissue, that has scarcely been touched yet and the condition has revealed an equally startling mass of facts unstudied and unexplored. The great watchword of driving out the saloon as the effective remedy for the ills which follow, fails in many ways. While it is most commendable and, from a layman's point of view, is the most practical measure possible, yet, when studied scientifically, this measure does not go far enough back. It does not reach the real causes, which are at the bottom of the alcoholic evil. It is not stopping the typhoid germs from trickling into the watershed and producing the epidemic; it is studying the effects and the water from which it is supposed to come, and leaving the source unknown. The disease and deaths from alcohol are most interesting studies and give little or no intimation of the vast undiscovered country from which these streams of degeneration come.

The phenomena and symptomology of alcoholism and inebriety is most complex and confusing and, unlike any other disease or degeneration, cannot be stated in terms of exactness. The lay literature is simply voluminous on this point and the medical literature follows in the same confusional way, simply because the causes are unknown. What makes men drink spirits is as much a mystery to-day as Central Africa was fifty years ago. Fortunately, there are a great many collateral facts and distinct intimations from medical studies in hospitals and at the bedside that point to this new realm. Every practicing physician is in constant contact with psychical and physical causes concerning the drink evil, which, if they knew how to interpret, would result in as great discoveries as that which come from electricity. One fact seems to be generally agreed upon, that the alcoholic and all the degenerative classes are being born and bred to-day in our homes and communities and will appear to-morrow with the same absolute certainty that plants grow from seeds in favorable soils. Preventative medicine has scarcely

touched this subject, because it has been concerned with effects more than the study of causes. In a few instances the possibilities of medical work in this direction have been almost phenomenal. As a result, many fevers and so-called scourges and smallpox have practically disappeared. This is the line of future discovery and work.

A research foundation has been organized at Hartford, Conn., to study the causes back of the saloon and back of the use of alcohol, to find out what propelling forces drive men to the use of spirits and narcotics against their better judgment. What conditions, inherited, or acquired from neutritional, chemical and bacterial sources, force and develop a species of degeneration which calls for anaesthesia and narcotism? That is the new study and it goes back to sources and causes that have never been studied before, only in a general and most cursory way. Physicians, by their training and contact with the family life and history, are in the best possible condition to appreciate and assist in such a work. It is assumed that the facts are abundant, only needing corralation, examination and study, and from this study there will come new measures and new means for prevention and treatment that will bye and bye not only stamp out this evil but many associated ones and lift the race to a higher level of health. It is work along this line that will be the final consummation of the great temperance problem and how they can be overcome.

STRABISMUS AND ITS TREATMENT.

Read before the Medical Society of the County of Albany, November 23, 1916

By EDWARD A. STAPLETON, M. D.,

Albany, N. Y.

In reading this paper on squint, its causes and treatment, my idea is to present same so that it may be some use to the general practitioner and not the specialist who is already familiar with most of the material I am to present. Yet, feel that some points may be of interest to the specialist, although he may not fully agree with same.

We will first take up the definition of squint or strabismus. In Dorland's Medical Dictionary the following definition is given:

"It is a deviation of one of the eyes from its proper direction, so that the visual axes cannot both be directed simultaneously at the same objective point."

Squint may be subdivided into three classes: First, when the eye turns in, called Internal Squint, Internal Strabismus or Esotropia, also called Convergent Strabismus; second, when the eye turns out, called External Squint, External Strabismus, Strabismus Divergens, Insufficiency of the Interni and Exotropia; and third, Vertical Squint, Vertical Strabismus or Hypertropia, the eye turning up or down, or the elevation of one visual axis above the other.

As to the Cause or Etiology of Squint.

No one thing can be said to cause squint, many factors entering into the cause and many things that might be said to cause squint are admitted.

Donders was one of the first to come out with a theory for the cause of squint, which was accepted for a long time, and which still explains the cause of a great many cases. He says that it depends on the abnormal convergence stimuli set up by the refractive error, this being particularly the case in internal squint.

Worth, of London, believes that most cases of squint are due to insufficient fusion power and that the trouble is of a central rather than a local lesion. Francis Valk, of New York, says that the true cause of squint resides in the muscular balance of the eye, as a weak muscular action of the internus, the externus overacting, or vice versa.

Von Sicherer believes that injuries to the eyes at the time of delivery have much to do with squint and amblyopia which we find in later years, caused at that time by hemorrhage into the retina destroying part of it. It would be interesting to ascertain just how many hard instrument cases have developed strabismus. I can remember one of my own cases when I was doing general practice, in which I exerted considerable strength, where the child developed a squint at about the sixth month.

Heredity seems to play a large part in the cause of squint. At present I have a boy nine (9) years old, with an internal

A

C

A. Shows patient's pictures after tenotomy of Superior Rectus, right eye. Before tenotomy only white of eye was visible. Picture 1, fixing with left eye, right eye turned up. Picture 2, fixing with right eye, left eye turned down.

C. Patient using eyes, elevating left lid with Frontalis Muscle.

B

D

B. Shows patient after an advancement of Inferior Rectus, right eye and partial tenotomy of Inferior Rectus, left eye. Note position of eyes when fixing with each separately.

D. Shows patient fixing with both eyes after complete tenotomy of Inferior Rectus, left eye, and advancement of Levator Palpebrae left eye.

strabismus, who has a paternal aunt who is cross-eyed and three other paternal aunts, each of whom has one cross-eyed child.

Internal squint may be constant or alternating; in the first instance, the patient always fixes with the same eye (vision usually good in that eye) while the other eye deviates (vision bad in this eye). In alternating internal strabismus, the patient can fix with either eye, while the other is deviated, vision in either eye being about the same. Hope to present such a case tonight. External strabismus may be constant or alternating. In the constant, the one eye fixes while the other turns out; in the alternating external strabismus or exotropia, the patient fixes with either eye while the other is turned out. In the first, the vision is poor in one eye and good in the other; in the alternating type, the vision is about the same in both eyes and usually fairly good. External strabismus or exotropia is usually found in myopes and internal strabismus or esotropia in hyperopes. Internal strabismus usually shows itself early in life while external strabismus seldom shows up until about puberty.

Another interesting fact is that 80 per cent of the cases of internal strabismus affect the left eye, while the right turns out in the same percentage in external strabismus.

Vertical strabismus may also be divided into a constant and an alternating type. The former, constant type, is when one eye always does the fixing while the other deviates upward or downward, and patient usually has a partial or total loss of vision in the deviating eye. The alternating is when the vision is about the same in both eyes and patient fixes with either eye, while the other turns upward or downward. Will present a case similar to the last mentioned,—one very extreme and unusual.

Symptoms.

The symptoms are:

First, subjective:—Two of these patients who were operated upon, alternating internal and external cases, came for relief from the severe headaches from which they were suffering, headaches of three and four days' duration at a time. The third had pronounced headaches when stooping over and working, which was a vertical strabismus case.

GROUP II—ALTERNATING INTERNAL STRABISMUS

1. Shows patient fixing with right eye, left eye turned in.

2. Shows patient fixing with left eye, right eye turned in.

3. After operation. Showing patient fixing with both eyes.

Second, objective:—Objectively, the physician notices that while one eye is fixing, the other eye is turning in, out or up. Different tests and measures are used of which I will only mention as the cover test, the perimeter measure, the linear measure, the diplopia test and the tropometer.

Treatment.

The treatment of squint may be non-operative or operative, depending upon the kind of squint, age of patient, etc., etc.

If a squint is noticed in a child by the family physician, he should not advise the parents that the eyes will in all probability straighten up all right, or that the child will grow out of it. Perhaps the eyes may straighten, but usually you will find that the eye which had deviated is now partly blind, a condition which probably could be averted if the child had been treated when first noticed.

The treatment in youngsters consists in refracting carefully under atropine and prescribing the proper correction. This can be done in children as early as a year old. The atropine is usually continued in the fixing eye for some weeks, allowing the deviating eye to return to normal and making it do the work, thus developing the retinal function.

Worth's amblyoscope is used for the education of the fusion faculty, also the stereoscope.

Men differ as to the right time for operating. Some say that operation can be performed as early as five, others that the best time is around nine years of age, while in the Vienna clinics they prefer to operate after the fourteenth year.

Some operators prefer doing a simple tenotomy, others the advancement, while others choose to combine the above two, doing in some cases a partial or total tenotomy of the muscle that is deviating the eye from the normal axis. At present the advancement operation is the most used, as operators feel that they can control the results better, doing a partial tenotomy later if necessary.

In concluding, I present three cases operated upon:

Case I.—Alternating internal strabismus. Patient Miss C. C., aged 25, first seen September 16th, 1916. Complains of severe headaches, that

GROUP III—ALTERNATING EXTERNAL STRABISMUS

1. Shows patient before operation, fixing with right eye, left turning out.

2. Shows patient fixing with both eyes after operation.

IV—CASE OF EXOTROPIA AND HYPERTROPIA (CONSTANT)

RESULT AFTER OPERATION

Before operation right eye turned up about 10° and out about 20°. Was unable to get picture of patient before operation as she was extremely sensitive about the eye.

sometimes last three or four days. Pain radiates from back of head to temporal region. Vision at time of examination was 10/10 with either eye. Resection and advancement of both external recti was performed, correcting muscle condition and cosmetic appearance. Patient has been relieved of headaches. This patient was operated September 18th, 1916.

Case II.—Alternating external strabismus. Patient Mrs. C. J., aged 31. Date of first examination July 3rd, 1915, at which time patient complained of headaches for the past three years, worse of late and almost constant. Past history: Had spinal meningitis when three years of age. Vision, R, 12/10 L, 10/10. Wearing on R. eye + 1.50 D. Sph. and on L. + 1.25 D. Sph. Had about 30° of squint. Did a complete tenotomy of both external recti and a resection and advancement of both internal recti. I over-corrected patient producing 30° esophoria by the rotary prism, which showed up September 29, 1915, two days after operation. On October 1, 1915, there were but 11° of esophoria present and in July, 1916, the muscles balanced. Patient has been relieved of headaches and appearance improved.

Case III.—Vertical strabismus. Patient Mr. J. R., aged 21. Examined March 2, 1915. Complained of headache when stooping. When fixing with right eye, the left eye turned down as though it were closed, and when fixing with left eye, the right eye turned up, so that only the white of the eye was visible, about 25° of squint being present, a condition present since birth. Vision, R. 1/10, L. 2/10. Wearing R.-1.00 D. Cyl. ax 90, and L.-1.00 D. Cyl. ax 90, with which he was able to get 3/10. Under homatropine and cocaine took: R.-0.50 —3.00, 15 L.-1.25 —3.00 ax 165 with which he got 5/10 and 6/10. The first operation April 22, 1915, was a tenotomy of the superior rectus of the right eye, the second, May 21, 1915, was a partial tenotomy of the inferior rectus of the left eye and an advancement of the inferior rectus of the right eye, and the third June 21, 1916, was a complete tenotomy of the inferior rectus on the left eye and an advancement of the levator palpebrae of the left lid. Had a slight infection of the lid incision but it did not appear to affect the operation in any way.

THE MEDICAL ADMINISTRATION OF HEALTH INSURANCE.

By A. C. BURNHAM, M. D.

Since the introduction of the Mills bill in the State Legislature last winter there has been a gradually increasing interest displayed by the medical profession as to the part the physician must play in the administration of any system of insurance

against sickness, which has recently come to be known as "health insurance."

Health insurance was introduced in Germany about thirty years ago. After an extensive trial by Germany it was finally adopted by the other countries of Europe, so that today some modification of health insurance is found in both France and England as well as in many of the smaller countries of Europe.

If such a system is to be introduced into America, it would be the wisest policy for the physicians to post themselves fully upon the provisions of any act introduced to this end, so that they may make their influence felt to insure a practical, satisfactory and economical working of the strictly medical sections of the law.

The American Association for Labor Legislation, which is not, as its name might imply, an association in any way connected with trades unionism, through its committee on social insurance, has long been at work upon a tentative draft of an act* to insure the industrial wage-earner against disability due to sickness and injury. The committee consists of philanthropic workers, economists, physicians, statisticians, and others, who are working unselfishly for the betterment of the present day conditions.

Health insurance is not, as is sometimes imagined, simply another method by which labor attempts to harass capital, nor is it a means for more complete capitalistic control of the wage-earner. Indeed, if it were to be given a short definition it might better be termed "a method for the socialization of the practice of medicine," which would characterize its chief function and make its other provisions subsidiary to this. The theories of health insurance are sound and are based upon the belief that injury and disability of the human body should be included in the cost of production just as logically as injury and depreciation of machinery. It is upon this theory that the committee has apparently based its procedure and shaped the proposed law.

Whether one believes in the principle of health insurance or

* Health insurance, standards and tentative draft of an act. Copies may be secured from J. B. Andrews, secretary, 131 E. 23d street, New York City.

not it is impossible to mistake the motives of those who are responsible for its introduction in this country and any discussion of the subject must grant this in the beginning.

Briefly, the act contemplates the care of the health of all wage workers, including their dependents, whose yearly wage is $1,200 or less. Needless to say this will include a large proportion of the population and will require for its administration the services of a large number of physicians and nurses.

Just as protection against fire and theft have become more and more centralized with the passage of time, so must protection against sickness and disability progress toward centralization in spite of attempts of those within and without the medical profession to prevent it.

The powers of the state and municipal health boards have increased enormously within recent years and, in its broad sense, health insurance is only a further increase in the duties of a centralized health authority, in this case under the control of the state. In the third draft of the act (May, 1916) the question of medical administration is much more thoroughly dealt with than was the case in previous editions. It is now planned to have a physician on the Social Insurance Commission and provision is made for consultation with representatives of the medical profession on medical matters.

The benefits of the act, as outlined in section 7, are:

Medical, surgical and nursing attendance;

Medicines and surgical supplies;

Cash benefits;

Maternity benefits;

Funeral benefits;

Medical and surgical attendance and medicines for dependents.

The medical service includes the care of the sick by legally qualified physicians and nurses and hospital treatment when indicated. To quote from section 10:

"Provision for medical aid shall be made by the carriers by means of either:

"1. A panel of physicians to which legally qualified physicians shall have the right to belong, and from among whom the patients shall have free choice of physician, subject to the physi-

cian's right to refuse patients on grounds specified in regulations made under this act; provided, however, that no physician shall have on his list of insured patients more than 500 insured families nor more than 1,000 insured individuals;

"2. Salaried physicians in the employ of the carriers among which physicians the insured persons shall have reasonable free choice.

"3. District medical officers, engaged for the treatment of insured persons in prescribed areas;

"4. Combination of above methods."

If the medical profession is to be employed under the act, it lies in its power to exert its influence to make for the successful medical administration of the law and it is the duty of physicians to read and study the act so that they may be able to decide intelligently upon those provisions which may have especial bearing upon the future of the medical profession.

Recently, the writer has strongly advocated the state administration of health insurance by means of a State Department of Health somewhat along the lines of the Medical Department of the United States Army. There is much to be said in favor of such a plan and very little against it except that it will cause opposition to the act by the medical profession. Whether it is entirely practical or not is yet to be decided.

The panel system has been tried in England and under conditions as they were before the war was decidedly unsatisfactory both to the physician and the insured. The salaried physician in the employ of the insurance carriers may be ideal or may be open to serious abuses depending upon the character of the physicians employed. If uncontrolled it may become no better than the contract or lodge practice which has been open to so many evils. The method of district medical officers approaches the State Health Department plan and seems to have more advantages and to be open to fewer abuses than either of the other methods. This question is discussed in the booklet of the Committee on Social Insurance as follows:

"Proper provision for medical care is one of the most important problems in the efficient administration of health insur-

ance. The tentative plan—many of the details of which should be left to regulations to be made by the Commission and the medical advisory board—allows each fund or approved society to select the method of administration suitable to local conditions. Where the fund chooses the panel system, any legally qualified physician may join the panel, and the insured workmen shall have free choice among the physicians undertaking insurance practice. Since this system may not prove practicable in all districts, freedom should be left to provide medical care through other methods, such as salaried physicians, among whom there should be reasonable free choice, through physicians responsible for specified districts, or through any other method approved by the Commission."

Having decided upon the plan of service best adapted to the needs of the profession, the wage-earner and the state, it next becomes the duty of the medical profession to come to an agreement with the state as to the method of payment for services rendered.

Shall we have a fixed fee per visit as in some of the present compensation laws or shall we receive a per capita fee as is the custom in England? Both of these methods are open to serious objection and are not giving satisfaction wherever they are instituted upon a large scale.

It must be remembered that in these cases the insurance carriers will be losing money for the disability of each and every wage worker and that it is for their best interest to limit the period of disability as much as possible. To this end they must secure the best medical care that the available cash will secure. Except in the case of the insured dependents of the wage-earner, there will be nothing to be gained by penurious methods in dealing with the medical benefits. It will be the desire of the insurance carrier even more than the patient to secure the shortest possible period of disability compatible with good health.

The design of the physician should be similar to that of the insurance carriers, but not for the same reason. The carriers will to all intents be fined for every day's illness after the fourth day. On the other hand, if the physician is paid by the fee system, we find that his remuneration will increase just so long

as his patients remain sick. If the carriers are powerless to indicate their own preferences as to the physician they employ, they will be working at cross purposes with the doctor whose salary they must pay. I will prognosticate that under these circumstances it will be no unusual thing to find patients kept away from work for two weeks or longer, because of an ordinary cold, just as I have seen patients under the present New York State Compensation Law, away from work for from twelve to fourteen weeks with a simple Colles' fracture and three or four weeks with a slight abrasion of the hand.

Theoretically the most satisfactory service would be obtained by salaried officers whose duty coincides with the best interests of the patients and of the community.

Upon this subject the Committee on Social Insurance says in part:

"The capitation payment, of so much per person per year, common now in lodge practice, has in it elements which bring about an undue amount of work, and in turn forces neglectful, hurried service to the patients. Another plan is that of engaging a salaried physician, similar to the arrangements now made by many railroads. Since no fund could employ many physicians, the limited choice of doctor might be unfavorably regarded by some of the insured persons. The advocates of this system claim that it offers peculiar advantages of selecting the physician most desirable for this work, and thus obtaining better service. A third method, payment per visit, is also possible. To the medical profession this method may be preferable because it establishes a quantitative relation between services and remuneration, and to the patient because it probably secures more careful attention from the doctor and thus eliminates the chief fault of the capitation system. On the other hand, medical care under this system may put a heavier burden upon the funds administering benefits. A compromise between this and capitation may be made by which a total sum, calculated on the per capita basis, is distributed among physicians in accordance with the services rendered by each. Instead of the elaborate fee schedule common under workmen's compensation, a more simple arrangement is made whereby a physician is paid pro rata for office and house

visits. Although this effectively meets the chief objection to a capitation payment, it may be undesirable to the physician since the actual payment for each visit may decrease in proportion as work increases. However, the provision of a fixed amount divided according to services has administrative advantages since the total amount paid for medical aid is a fairly constant charge upon each fund.

"But whichever system be adopted, one thing is clear; all medical service to the insured will be paid for, including the unremunerated dispensary practice of today. The problem becomes one of deciding which method of arranging for the 100 per cent. collections of the future is preferable, in the interests alike of patients, doctors, and administrators."

From the above it is apparent that the whole question of remuneration for the physician under any health insurance act is a very complicated one and it is impossible in the limits of this paper to more than indicate the different methods of payments and some of the objections which may arise. Remember, there is to be a fixed annual amount to pay for the medical care of a given number of wage-earners and this must be distributed so as to do the most good. Let us suppose that the medical insurance premiums for 1,000 insured amounts to $5,000, that is, $5 per capita. How shall this be expended to the best advantage? If the sum be less than $5,000 the problem becomes more difficult; if the individual premium is greater than $5, it becomes correspondingly easier to secure the type of services desired.

It is evidently the purpose of the Committee to make a fixed sum for medical benefits go as far as possible toward the care of invalid and disabled wage-earners. How this may be best accomplished is the question before the medical profession.

Editorial

> For the cure of wounds, the Spaniards found the Mexican remedies most efficacious. Cortes himself was cured by one of their doctors of a severe wound in the head, received at Otaneba, through which we lately passed. For fractures, for humours, for everything they had their remedy; sometimes pulverizing the seeds of plants, and attributing much of their efficacy to the superstitious ceremonies and prayers which they used while applying them, especially those which they offered up to *Tzapotlatenan,* the goddess of medicine.
>
> *Life in Mexico* — MADAME CALDERON DE LA BARCA

✠ ✠ ✠

Medicine and the Church.

There can be no question of the debt of medicine to the church. Whatever the defects of practice arising from ignorance, from credulity, from superstition, or even from expediency, the healing art took fresh vigor from the compassion for suffering, which is one of the vital elements of Christianity. Even through the Dark Ages of crude and empiric methods the practice was sustained to inaugurate and aid the brighter scientific period. The influence of the church may be seen to-day in the architecture and administration of hospitals in which the long corridors, flanked on either side with rooms, and the administration in the hands of religious orders recall the era of the monasteries. There is good reason for this persistence of the ecclesiastical idea, for the church can hardly be said to accomplish its whole duty when it fails to provide for the distresses of its members. With the advent of scientific medicine however, intolerance was manifested. The great epidemics of the Middle Ages demanded more universal action and relief than could be afforded by limited organizations, and municipal hospitals sprang into existence. In these hospitals originated clinical observation and practice, and at about the same time the pioneer anatomists, against the opposition of the church, began the study of the structure of the human body, which was the inspiration of modern medicine. Science, of course, recognizes no creed, and the ruthless laws of nature are not susceptible to modification

by ritual. Church hospitals remain, and should remain, as a necessary expression of the charity of mankind, but their existence is assured only upon liberal recognition and application of technical progress. The best methods of science are available, and expert administration is required for every institution, whether secular or religious. There may be contention and doubt as to the correctness of many theories of practice, but there should be no controversy between religion and science when the comfort or life of the individual is at stake.

There were some curious and almost humorous incidents in the European trip of Miss Dorothea L. Dix in the early fifties. Miss Dix had spent many years in an aggressive and successful campaign in the various states of the Union for the relief of the neglected insane. She conceived the plan of securing a grant from Congress of twelve million acres of land for the creation of a fund for the relief of the insane, the blind, and the deaf and dumb. Six years she labored in the interests of this legislation, and in 1854 attained success in so far as to accomplish the enactment of the necessary laws by Congress. President Pierce, however, vetoed the bill, and depressed in spirit and exhausted from this crushing reverse Miss Dix retreated to Europe for recuperation. Within a month of her arrival her interest was aroused, and with characteristic indomitable spirit she invaded Scotland and proceeded to investigate the abuses of the insane. The campaign was a short and aggressive one. The Scottish officials were not sympathetic, and Miss Dix hurriedly journeyed to London to lay her findings before the Home Secretary. Success attended her efforts and Sir George Gray, in a speech before the House of Commons, advocated the necessary remedies but "deplored the fact that the inauguration of so needed a reform should have been left to the initiative of a foreigner, and that foreigner a woman, and that woman a dissenter." After some similar activities on the Channel Islands, Miss Dix traveled upon the Continent, and in Rome "found a hospital for the insane so very bad I set about the difficult task of reform at once, and during the fourteen days I was there, so far succeeded as to have Papal promise and Cardinal assurance of immediate action in remedying abuses and supplying

deficiencies." Miss Dix was cordially received by Pope Pius IX, but His Holiness adjourned the conference to permit personal investigation. "At the second audience granted Miss Dix, the Pope freely acknowledged his distress at the condition of the asylum, and warmly thanked her, a woman and Protestant, for crossing the seas to call to his attention these cruelly treated members of his flock."

In Constantinople Miss Dix found the Turkish institutions to be above criticism, and the Mohammedan hospitals better managed than those of Italy. It appeared that this superior condition was due to the work and influence of a Turkish gentleman who had been impressed with the conduct of Paris hospitals.

This experience of Miss Dix's is rather a surprising revelation of liberality of thought and religious feeling. Three-quarters of a century ago the Church of England, the Church of Rome, the Mohammedan and a "Dissenter" found common ground in work for the relief of the sick.

Public Health

Edited by Arthur Sautter, M. D.

DEPARTMENT OF PUBLIC SAFETY, BUREAU OF HEALTH, ALBANY, N. Y.
ABSTRACT OF VITAL STATISTICS, DECEMBER, 1916.
COMPILED BY WILLIAM F. FULLGRAFF, REGISTRAR.

Deaths.

Consumption	20
Typhoid fever	1
Scarlet fever	0
Measles	2
Whooping cough	0
Diphtheria and croup	3
Grippe	4
Diarrheal diseases	2
Pneumonia	12
Broncho pneumonia	8
Bright's disease	15
Apoplexy	7
Cancer	11
Accidents and violence	8

Deaths under one year	21
Deaths over seventy years	36
Death rate	18.40
Death rate less non-residents	16.05

Deaths in Institutions.

	Non-Resident.	Resident.
Albany Hospital	10	11
Albany Hospital Camp	0	6
St. Peter's Hospital	1	3
Homeopathic Hospital	2	7
St. Margaret's House	0	3
Child's Hospital	1	0
Albany County Hospital	4	0
Hospital for Incurables	1	1
Home for the Aged	0	2
Maternity Hospital	1	7
Public places	2	1
	22	41

Births	198
Still births	10

Bureau of Communicable Disease.

Cases Reported.

Typhoid fever	12
Scarlet fever	12
Diphtheria and croup	15
Chickenpox	117
Measles	69
Whooping cough	0
Tuberculosis	41
Mumps	4
Septic sore throat	2
Trachoma	4
Ophthalmia neonatorum	1
Total	277

Number of days quarantine for scarlet fever:
Longest..... 36 Shortest..... 30 Average..... 31 5/10
Number of days quarantine for diphtheria:
Longest..... 30 Shortest..... 10 Average..... 16 1/4
Fumigations:
Houses..... 32 Rooms..... 207
Milk bottles disinfected..... 45

Communicable Disease in Relation to Schools.	D.	S.F
Public School No. 17	1	3
Public School No. 18	..	1
Albany Business College	..	1
Lady Help of Christians	..	1
St. Patrick's Institute	..	1
St. Ann's School	2	1
Blessed Sacrament Institute	..	1

Tuberculosis.

Living cases on record December 1, 1916		637
Cases reported:		
By card	41	
Dead cases by certificate	0	
		41
		678
Dead cases previously reported	20	
Dead cases not previously reported	0	
		20
Living cases on record January 1, 1917		658
Total tuberculosis death certificates filed during December, 1916		20
Non-resident deaths:		
Albany Hospital Camp		1
Resident deaths		19
Tuberculosis		50
Scabies		5
Total		55
Physicians visited		16
Investigations		7

Bender Laboratory Report.

Diphtheria.

Initial positive	22
Initial negative	188
Release positive	24
Release negative	57
Suspicious	6
No growth	3
Total	300

Sputum for Tuberculosis.

Positive	28
Negative	67
Total	95

Widals.

Positive	19
Negative	26
Suspicious	13
Total	58

Wassermann tests	135
Milk analyses	19

BUREAU OF NUISANCES.

Complaints made	36
Inspections	62
Plumbing	41
Sanitary	21
Reinspections	79
Plumbing	36
Sanitary	43

HEARINGS.

Cases heard before health officer	7

Nature of Cases.

Filthy premises	2
Manure	3
Plumbing	2

Disposition of Cases.

Abated	4
Ordered for reinspection	3

BUREAU OF PLUMBING, DRAINAGE AND VENTILATION.

Inspections	210
Old houses	63
New houses	147
Permits issued	70
Plumbing	68
Building	2
Plans submitted	36

Old buildings	14
New buildings	22
Houses tested	45
Peppermint	3
Water test	42
Houses examined	21
Re-examined	59
Valid	5
Without cause	16

Dead Animal Report.

Horses removed	28
Dogs removed	195
Cats removed	202
Total	425

Bureau of Markets and Milk.

Public market inspections	19
Market inspections	112
Fish market inspections	11
Packing house inspections	1
Rendering plant inspections	1
Slaughter house inspections	1
Milk depots inspected	11
Milk houses inspected	39
Milk cans inspected	240
Dairies inspected	39
Cows examined	455
Cows quarantined	3
Lactometer readings	97
Temperature readings	97
Fat tests	62
Sediment tests	42
Chemical tests	35
Bacterial counts	53
Complaints investigated	1
Cans condensed milk condemned	15

Miscellaneous.

Cards posted for contagious disease	20
Cards removed	14
Notices served on schools	177
Notices served on factories	20
Notices served on stores	11

Postal card returns sent to doctors		20
Postal card returns received from doctors		12
Inspections and reinspections		28
Work certificates issued to children		22
Vaccinations		9
Cases assigned to health physicians		65
Calls made		119
Garbage collected from 1st district	bbls.	178
Garbage collected from 2nd district	bbls.	173
Garbage collected from 3rd district	bbls.	201

Hospital and College Notes

Edited by Clarence F. Graham, M. D.

Albany Hospital.

The past three months have been a period of notable progress at the Albany Hospital. In spite of the burden of debt under which the hospital was laboring, the Board of Governors saw fit to incur a further expense in the changes to be described, and the results already obtained have amply vindicated the wisdom of their decision.

The operating suite has been entirely refinished, with the addition of necessary plumbing and electrical fixtures, and the scrub-up room for the staff has been enlarged and modernized. A dark room for eye, nose and throat operations has been prepared, and several new sterilizers have been installed. These changes, though long planned, were finally made imperative by the great increase in operative work in this department.

The enlargement of the scrub-up room made possible the addition of a small detention room to the children's ward. Here all children can be quarantined for some days before being admitted to the general ward.

An entirely new clinical laboratory has been constructed on the top floor of the building formerly used as the Nurses' Home and vacant for the last two years.

The rapidly increasing importance of laboratory procedures for medical diagnosis has made this "clinician's operating room" as necessary as the surgeon's operating room, and the clinical laboratory has been organized as a separate department of the hospital under the supervision of the medical service. Nine rooms have been completely outfitted with benches, plumbing and apparatus, leaving about half of the floor free for later expansion as this becomes necessary. The laboratory group comprises a receiving room for specimens, a stock room, an office, laboratories for the medical and surgical divisions, a photographic dark room, a pathological room, a physiological room, and a large chemical laboratory. Subsidiary to the main laboratory are a ward laboratory

adjoining ward Dii for student use, a laboratory for the use of the staff, and small laboratories connected with the South End and Hospital Dispensaries. A graduate nurse gives her entire time to the management of the clinical laboratory and even enters the laboratory reports in the histories. The fortunate circumstance of the hospital's connection with the Albany Medical College will make it possible to maintain a chemical department for a fraction of the expense which this entails upon hospitals not so situated. The professor of Physiological Chemistry of the Medical College is ex-officio consulting chemist to the hospital, and a technical assistant will soon be trained for the routine work. The rapid extension of accurate chemical investigation to the problems of diagnosis and treatment promises to make the chemical laboratory an essential part of every modern hospital in the near future, and the Albany Hospital is indeed to be congratulated on having recognized this necessity so early.

The organization of the clinical laboratory has already resulted in a great increase in the laboratory work done in the hospital, as indicated by the report for the month of December, 1916:

Single specimens of urine examined	485
Twenty-four hour specimens	74
Stool examinations	15
Gastric contents	1
Quantitative sugar estimations	12
Phenolsulphonephthalein tests	23

In December the hospital was visited by Dr. Winford H. Smith, the superintendent of the Johns Hopkins Hospital, who, at the request of the Board of Governors, made a general survey of the institution and submitted a report embodying his recommendations for a constructive program.

On January 1, 1917, Miss Sally Johnson assumed the position of Superintendent of Nurses. Miss Johnson was formerly assistant superintendent of nurses of the Peter Bent Brigham Hospital in Boston. She is a graduate of the Massachusetts General Hospital, and the McLean Hospital of Waverly. Miss Johnson brings with her associates of her own selection to fill the positions of Operating Room Supervisor, Head Nurse of the Tuberculosis Sanitorium, and Instructress in Practical Nursing.

The Board of Governors of the hospital has decided upon a campaign with the purpose of raising $350,000 to clear away past indebtedness and provide for future extension along constructive lines. The recent improvements in the laboratory have involved a considerable outlay, and will add noticeably to the running expenses, while not directly producing more revenue. The financial campaign will be started in the near future, and it is sincerely to be hoped that it will attain its goal.

Albany Medical College.

Under the direction of the State Department of Health, a clinic for the after care of poliomyelitis victims was held in the Albany Medical College on January 12. The clinic was open to the medical profession and the interested public, and many visitors registered during the morning and afternoon sessions, while the patients were examined and their treatment outlined. The anteroom to the dean's office served as a waiting room for patients as they entered the building, and the clinical histories were taken in the office itself. A dressing room was improvised from the students' smoking room, and the patients, when prepared for examination, were taken into the newly furnished physiological laboratory where the twenty-four firmly constructed laboratory benches answered admirably as examining tables. For the adult patients the research rooms served as dressing rooms, and movable screens were utilized to subdivide the larger room.

Dr. Robert Lovett of Boston conducted the clinic, and his organization was a splendid example of what such a working team should be. With three medical assistants, over a dozen nurses, and several stenographers and volunteer helpers, the examinations were conducted with a machine-like thoroughness and speed that made a most satisfactory impression. The nurses, working in pairs, tested every accessible muscle group of the body, first for gross paralyses, and then by spring balances for the actual degree of paralysis, when any was discovered. Abnormal findings were recorded on printed record sheets of unusual completeness so that Dr. Lovett could at once arrive at the essential condition and demonstrate the unusual features of each case to the interested circle of spectators that surrounded him. In case the physician in attendance upon a patient was present, the demonstration was directed to him, and in his absence, a report was dictated on the spot, with an outline of the suggested treatement to be mailed at the close of the clinic. Certain necessary orthopedic apparatus was sketched and immediately ordered from the Harvard Medical School shop when the parents of patients so desired. A number of the more interesting cases were exhibited in the amphitheater on the second floor.

It is not the purpose of those in charge of the clinics to take the control of the cases out of the hands of the original attendant, but rather to assist him in his treatment by their wider experience. Accordingly, where muscle training is necessary, the health authorities will instruct the physician in the proper method of application, if he wishes, will instruct the family, or will send a nurse to carry out the treatment.

Many of the cases date only from the past summer or autumn, and are not yet ready for any active measures, but the clinic has been of great value if it has only backed up the enforcement of a "masterful inactivity," and kept the insistence of impatient parents from compelling harmful exercises.

This clinic in Albany is but one of a series which the State Department of Health is conducting in the various affected districts, and at least one more clinic will be held in Albany after a suitable interval to continue the after care of the cases already examined. Many ounces of prevention could not prevent the epidemic and the State is equally liberal with its pound of cure.

Medical News

Edited by Arthur J. Bedell, M. D.

Albany Guild for the Care of the Sick.—Department of Visiting Nursing.—Statistics for December, 1916.—Number of new cases, 229; classified as follows: Dispensary patients receiving home care, 35; district cases reported by health physicians, 3; charity cases reported by other physicians, 53; moderate income patients, 69; metropolitan patients, 69; old cases still under treatment, 525; total number of cases under nursing care during month, 754. Classification of diseases for the new cases: Medical, 31; surgical, 14; gynecological, 3; obstetrical under professional care, mothers 52, infants 40; eye and ear, 1; skin, 0; throat and nose, 2; dental, 0; infectious diseases in the medical list, 83; surgical list, 33. Disposition: Removed to hospitals, 14; deaths, 19; discharged cured, 116; improved, 39; unimproved, 19; number of patients still remaining under care, 547.

Special Obstetric Department.—Number of obstetricians in charge of cases, 2; students in attendance, 2; nurses, 2; patients carried over from last month, 1; new patients, 4; patients discharged, 3; visits by head obstetrician, 0; by attending obstetrician, 24; by students, 10; by nurses, 31; total number of visits for this department, 65.

Visits by Guild Nurses (all departments).—Number of visits with nursing treatment, 1,308; for professional supervision of convalescents, 497; total number of visits, 1,805; paid cases, 764; charity cases, 544; unrecorded cases, 497; cases reported to the Guild by 1 health physician, and 49 other physicians, graduate nurses 8, certified nurses 2, pupil nurses 5 on duty.

Dispensary Report.—Number of clinics held, 90; new patients, 73; old patients, 338; total number of patients treated during month, 411. Classification of clinics held: Surgical, 11; nose and throat, 9; eye and ear, 14; skin and genito-urinary, 6; medical, 11; pre-natal, 5; lung, 9; dental, 0; nervous, 3; stomach, 5; children, 9; gynecological, 8.

Albany Guild for the Care of the Sick.—Department of Visiting Nursing.—Statistics for Year 1916.—Number of new cases, 2,219; classified as follows: Dispensary patients receiving home care, 206; district cases reported by health physicians, 48; charity cases reported by other physicians, 610; moderate income patients, 846; metropolitan

patients, 509; old cases still under treatment, 540; total number of cases under nursing care during year, 2,759. Classification of diseases for the new cases: Medical, 365; surgical, 134; gynecological, 45; obstetrical under professional care, mothers 515, infants 460; eye and ear, 22; skin, 7; throat and nose, 9; dental, 0; infectious diseases in the medical list, 652; surgical list, 10. Disposition: Removed to hospitals, 182; deaths, 268; discharged cured, 1,210; improved, 430; unimproved, 122; number of patients still remaining under care, 547.

Special Obstetric Department.—Number of obstetricians in charge of cases, 5; students in attendance, 15; nurses in attendance, 7; patients carried over from last year, 1; new patients during year, 48; patients discharged, 47; visits by head obstetrician, 2; by attending obstetrician, 309; by students, 234; by nurses, 446; total number of visits for this department, 991.

Visits of Nurses (all departments).—Number of visits with nursing treatment, 15,434; for professional supervision of convalescents, 8,109; total number of visits, 23,543; paid cases, 9,411; charity cases, 6,023; unrecorded cases, 8,109; cases reported to the Guild by 7 health physicians, and 135 other physicians, graduate nurses 8, certified nurses 2, pupil nurses 7 on duty.

Dispensary Report.—Number of clinics held, 1,066; new patients, 1,568; old patients, 4,836; total number of patients treated during year, 6,404, Classification of clinics held: Surgical, 152; nose and throat, 96; eye and ear, 190; skin and genito-urinary, 79; medical, 144; pre-natal, 8; lung, 88; dental, 0; nervous, 41; stomach, 41; children, 127; gynecological, 100.

Medical Society of the County of Albany.—A special meeting of the Medical Society of the County of Albany was held at the Albany County Court House, Wednesday, January 10, 1917, at 8.30 p. m. Dr. S. J. Kopetzky, New York City, addressed the Society on "The Medical Plan Under Compulsory Health Insurance." A resolution was adopted opposing the plan.

The regular meeting of this Society was held at the Albany Court House, Thursday, January 18, 1917, at 8.30 p. m. The following papers were read: "Infectious Arthritis," Dr. W. T. Shields, Troy, N. Y.; "Tarsalgia and Metatarsalgia," Dr. E. W. Hannock, Albany, N. Y.; "Obstructions of the Esophagus," Dr. F. C. Myers, Albany, N. Y.

Medical Society of the County of Schenectady.—The regular meeting of the Medical Society of the County of Schenectady was held in its rooms in the New County Building, Tuesday, January 9, 1917, at 8.30 p. m. Scientific program: "Simplified Infant Feeding," Dr. R. H. Dennett, New York City.

A special meeting of this Society was held Tuesday, January 16th, at 8.30 p. m. Dr. James F. Rooney, of Albany, addressed the Society on

Compulsory Health Insurance. The Society passed unanimously a resolution in which is stated its strong opposition to the plan as now proposed.

Saratoga Springs Medical Society.—The regular meeting of the Saratoga Springs Medical Society was held at the Elks Club, Friday, January 19, 1917, at 8.30 P. M. Program: Paper, "Actinomycosis," Dr. G. S. Towne. Report of cases by Doctors Resseguie, Ledlie, Loop and King.

Medical Staff of the Albany Hospital.—The regular meeting of the Medical Staff of the Albany Hospital was held at the hospital, on Saturday, January 20th, 1917.

State Department of Health.—A free clinic for the after care of paralysis following cases of poliomyelitis was held by the State Department of Health, at the Albany Medical College, Albany, N. Y., on Friday, January 12, 1917, from 9 A. M. to 5 P. M.

Resignations from St. Peter's Hospital.—Dr. Elting and Dr. Donhauser have declined appointments to the staff of St. Peter's Hospital in the following letters addressed to the Rev. Mother Berchmaans, who is in charge of the Hospital. Dr. Elting writes:

"The notification of my appointment as chief surgeon of St. Peter's Hospital has just been received. In all other hospitals with which I am acquainted this is a purely honorary position, and, inasmuch as four attending surgeons have been appointed, I am left without any ward service. I am therefore in a position of responsibility without any power to insure what I regard as the proper treatment of the patients, which is the chief and essential function of the hospital. I am unwilling to assume this responsibility and must decline the appointment.

"I should also like to have the public of Albany know that I am in no way connected with the hospital and not responsible for the future conduct of the surgical department.

"It is with deep regret that I sever my connection with the institution, to which, over a period of many years, I have devoted my best endeavors."

Dr. Donhauser's letter states:

"It is with regret that I tender my resignation as assistant attending surgeon at St. Peter's Hospital. I have for several years taken a deep interest in the public work at the hospital with Dr. Elting as chief of the surgical department, and the recent radical changes induce this step on my part."

Cost of Foot and Mouth Disease.—The combined expenditures of the federal and State governments for fighting foot and mouth disease last year was $9,000,000, according to the report of the United States Bureau of Animal Industry.

Treatment of the Insane in the Canal Zone.—The transfer of the American insane patients under treatment in the Panama Canal Zone to the Government Hospital for the Insane in the District of Columbia, has been recommended by the secretary of war. The secretary has asked for the enactment of the legislation necessary for this purpose. It is planned, however, on ascertaining the legal residence of any such patient, to return him to the place of such residence. The secretary of the interior, under whom the Government Hospital for the Insane is administered, and the superintendent of the hospital have approved the plan.

Oleomargarin from Pasteurized Dairy Products.—After June 30, 1917, milk and cream used in the preparation of oleomargarin must be pasteurized and the butter used for this purpose must be made only from pasteurized dairy products, according to service and regulatory announcements of the United States Bureau of Animal Industry. Proprietors and operators of official oleomargarin-producing establishments will be required to furnish inspectors with satisfactory evidence that the butter used is only made from such products, and to give advance information of proposed sources of the butter supplies so that the matter of pasteurization can be investigated in cases of doubt. In lieu of the use of butter made from pasteurized dairy products, however, the butter itself may be pasteurized by heating it to a temperature of not less than 180° F.

Ban on Heroin.—All physicians of the United States Public Health Service have recently been ordered not to dispense any heroin for any purpose hereafter, and to return to headquarters any quantities of the drug they may have on hand. This action has been taken in the hope of counteracting the increasing use of heroin throughout the country.

American Congress on Internal Medicine.—The first scientific session of the American Congress on Internal Medicine which was chartered only last year, was held at the Hotel Astor, New York City, on December 28th and 29th, under the presidency of Dr. R. W. Wilcox who addressed the members on "The Domain of Internal Medicine and the Purport of the Congress." On the first day of the Congress, there was a discussion on the "Ductless Glands in Cardio-vascular Diseases and Dementia Precox" and on the second day of the Congress, a symposium on "Duodenal Ulcer."

Red Cross Meeting.—At the annual meeting of the American Red Cross, December 13, 1916, the treasurer's report showed that the organization had expended $543,535 during the eleven months preceding December 1, for war relief, exclusive of hospital and medical supplies sent abroad.

Hospitals for Insane Overcrowded.—The State Hospital Commission reports that $2,000,000 a year for the next five years must be spent to provide for the insane in New York. There are 34,000 insane persons in the State hospitals, which have a normal capacity of 28,000. The commission favors the construction of a new hospital at Mohansic and of new buildings at Marcy near Utica where 1,500 of the insane of New York City could be sent.

United States Public Health Service.—Dangers of Pellagra Increase. —That there may be an increase in pellagra during the coming year on account of the rise in the cost of food-stuffs is the fear expressed in a statement issued by the U. S. Public Health Service to-day. As a result of government researches it was found that pellagra is produced by an insufficient, poorly-balanced diet and that it can both be prevented and cured by the use of food containing elements in the proportion required by the body. The application of this knowledge greatly reduced pellagra in 1916 as compared with previous years. This reduction is believed by experts of the Public Health Service to have been due to improved economic conditions which enabled wage-earners to provide themselves with a better and more varied diet and to a wider dissemination of the knowledge of how the disease may be prevented. It is feared, however, that pellagra may increase in 1917 by reason of an increase in food cost out of proportion to the prosperity now enjoyed by this country. The great rise in the cost of forage, particularly cotton seed meal and hulls, is causing the people in many localities to sell their cows and thus there is danger that they will deprive themselves of milk, one of the most valuable pellagra preventing foods. The high cost of living has further served to bring about a reduction in many families in the amount of meat, eggs, beans and peas consumed, all of which are pellagra prophylactics. In effecting economies of this nature the general public should bear in mind the importance of a properly balanced diet and refrain from excluding, if possible, such valuable disease preventing foods. It is believed that unless this is done there will be a greater incidence of pellagra next spring.

Personals.—Dr. Frederic Crounse (A. M. C. '90), has removed from Altamont to 92 Willett street, Albany, N. Y.

—Dr. Ralph Sheldon (A. M. C. '94), is practising at Lyons, N. Y.

—Dr. Charles W. Tomlinson (A. M. C. '15), is engaged in active practice at Amsterdam, N. Y.

Died.—Dr. James A. Clyne (A. M. C. '86), a Fellow of the American Medical Association, once president of the Will County Illinois Medical Society, for twenty years local surgeon of the Chicago and Alton Railroad, health commissioner of Joliet in 1893 and 1894 died at his home recently, from disease of the throat, aged 56.

Current Medical Literature

REVIEWS AND NOTICES OF BOOKS

A Manual of Gynecology and Pelvic Surgery for Students and Practitioners. By ROLAND E. SKEEL, A. M., M. S., M. D., Associate Clinical Professor of Gynecology, Medical School of Western Reserve University; Visiting Surgeon and Gynecologist to St. Luke's Hospital, Cleveland; Fellow of American Association of Obstetricians and Gynecologists; Fellow of American College of Surgeons. Two hundred and eighty-nine illustrations. Philadelphia: P. Blakiston's Son & Co., 1916. Price $3 net.

As stated in the preface, this manual is intended to furnish a concise, practical working knowledge of gynecology with especial emphasis upon diagnosis and treatment. A great deal of information on the subject of diseases of women is crowded into this little manual. The book is well arranged and the illustrations are excellent. There are many book references intended for collateral reading by students. The author is to be commended for the acknowledgment of indebtedness to those writers whose opinions, methods, etc., he may have copied. This book is more complete than some manuals on this subject, and treats gynecology as a "highly specialized branch of surgery with a close relationship to obstetrics and demanding a thorough knowledge of general medicine for a proper appreciation of its relative importance in the medical field with its multiplicity of specialties." This book is to be highly recommended for medical students and general practitioners. T. L.

Two Strengths of Pituitrin

FOR several years we have marketed a standard pituitary extract under the name of "Pituitrin." The product is prepared from the posterior lobe of the pituitary gland and has come into extensive use in delayed parturition due to uterine inertia.

Being specifically intended for use in obstetrical work, this preparation will hereafter be called

PITUITRIN O.

—(Pituitrin obstetrical). Administered hypodermatically in properly selected cases, in the second stage of parturition, it stimulates uterine contraction, hastens delivery, prevents needless suffering of the mother, and diminishes the risk to the child which attends upon protracted labor.

We now announce a second preparation of the pituitary gland, to be known as

PITUITRIN S.

—(Pituitrin surgical). This product is intended specifically for use in the treatment of post-operative intestinal paresis, vesical atony, hemorrhage, shock, etc.

Pituitrin S. is twice the strength of Pituitrin O. Because of its exceptional potency it should not be used in obstetrical practice. To readily distinguish it from **Pituitrin O.** (obstetrical), the carton labels of **Pituitrin S.** (surgical) are printed with *red letters* on white paper.

PITUITRIN O.: Ampoules of 1 mil (1 Cc.) and ½ mil (½ Cc.); also bottles of ½ ounce (for oral administration).

PITUITRIN S.: Ampoules of 1 mil (1 Cc.) only.

LITERATURE SUPPLIED ON APPLICATION.

Home Offices and Laboratories,
Detroit, Michigan.

Parke, Davis & Co.

50 Years of Pharmaceutical Progress

The Bender Hygienic Laboratory

ALBANY, N. Y.

TRUSTEES

HARRY H. BENDER
DR. GEORGE E. GORHAM
DR. HENRY HUN
DR. EDGAR A. VANDER VEER
WILLARD M. DOUGLAS
JAMES B. McEWAN, JR.

STAFF

ELLIS KELLERT, M. D., Director
LAWRENCE J. EARLY, M. D.
STEPHEN H. CURTIS, M. D.

The attention of physicians is called to the advantages which this institution offers in methods of laboratory diagnosis. Many physicians, through lack of time, technical training, or proper laboratory equipment, find it difficult to utilize the many methods of microscopical and chemical examination, so essential to proper diagnosis. To the Alumni of the Albany Medical School, and to physicians generally, the Bender Laboratory offers at a moderate cost, facilities for such examinations. Animal inoculation, chemical, bacteriological and histological examinations will be made as the case requires.

The following directions are appended for the benefit of those who may forward material:

All specimens should be accompanied by a brief note of the clinical condition and a special reference to the character of the examination desired. Name and address of person to whom report is to be sent should be clearly indicated.

1.—Pathological material from either operation or autopsy should be wrapped in moist gauze surrounded by oiled paper or rubber protective. When it is not possible for material to reach the laboratory within twenty-four hours, it should be placed in alcohol (80%) or formalin solution (10%). Small fragments of tissue and the material from uterine curettage should always be so preserved.

2.—Sputum should be sent in clean wide-mouth bottles; the ordinary vaseline bottle answers all purposes. The same bottle is suitable for faeces. Urine should be in clean bottles containing not less than six ounces.

3.—Exudates and other material requiring a bacteriological examination by culture should be placed in containers previously sterilized by heat (not chemical disinfectants).

4.—Outfits for special purposes, as diphtheria cultures, Widal reaction, vaccines, Wassermann reactions, etc., will be sent upon application.

5.—Tissues and fluids for animal inoculation, e. g., hydrophobia, tetanus, tuberculosis, etc., are best sent packed in ice. In cases of suspected hydrophobia it is advisable to send the entire animal without injury to the brain or cord.

6.—Haematological examinations at the patient's home will be made by appointment.

7.—Milk and water for bacteriological examination should be sent in sterile glass containers, packed in ice. Special instructions for the collection of samples may be had upon application.

8.—Members of the staff are at all times available for the purpose of conducting post-mortem examinations.

9.—The fee for complete haematological examination at patient's home is $10.00; for post-mortem examination, according to the nature of the case and the time consumed; for the Wassermann reaction, $10.00; all other examinations, a uniform fee of $5.00. A special contract may be made for weekly or monthly examinations of milk. In the case of patients who cannot pay the full amount, these fees will be reduced.

Reports will be sent by telegraph if requested.

Letters and specimens should be addressed to

THE BENDER HYGIENIC LABORATORY,
LAKE AVENUE, ALBANY, N. Y.

THE BRANDOW PRINTING COMPANY, ALBANY, N. Y.

ALBANY HOSPITAL

New Scotland Avenue

MEDICAL AND SURGICAL STAFF

Consulting Staff

Physicians
HENRY HUN, M. D.
JOSEPH D. CRAIG, M. D.

Obstetrician
JAMES P. BOYD, M. D.

Physician-in-Chief to the Tuberculosis Department
HOWARD VAN RENSSELAER, M. D.

Electro-Therapeutist
EZRA A. BARTLETT, M. D.

Surgeon-in-Chief
ALBERT VANDER VEER, M. D.

Surgeon
SAMUEL R. MORROW, M. D.

Ophthalmologists and Otologists
CYRUS S. MERRILL, M. D.
HERMAN BENDELL, M. D.

Dermatologist
FREDERIC C. CURTIS, M. D.

Attending Staff

Physician
THOMAS ORDWAY, M. D.

Physician for Mental Diseases
J. MONTGOMERY MOSHER, M. D.

Gastro-Enterologist
LEO H. NEUMAN, M. D.

Neurologist
LASALLE ARCHAMBAULT, M. D.

Physician for Cutaneous and Contagious Diseases
ARTHUR SAUTTER, M. D.

Physicians to the Tuberculosis Department
ERASTUS CORNING, M. D.
MALCOLM DOUGLASS, M. D.

Pathologist
ELLIS KELLERT, M. D.

Surgeons
EDGAR A. VANDER VEER, M. D.
ARTHUR W. ELTING, M. D.

Gynecologist
JOHN A. SAMPSON, M. D.

Rhinologist and Laryngologist
EUGENE E. HINMAN, M. D.

Ophthalmologist and Otologist
ARTHUR J. BEDELL, M. D.

Obstetricians
G. EMORY LOCHNER, M. D.
H. JUDSON LIPES, M. D.
PAUL T. HARPER, M. D.

Orthopedist and Radiographer
JOHN M. BERRY, M. D.

Urologist (Surgical for Men)
JAMES N. VANDER VEER, M. D.

Associate Staff

Electro-Therapeutist
WM. G. LEWI, M. D.

Dentist
LEROY BLATNER, D. D. S.

Assistant Attending Staff

Assistant Attending Physicians
CLINTON B. HAWN, M. D.
L. WHITTINGTON GORHAM, M. D.

Assistant Attending Gastro-Enterologist
THEOBALD F. DOESCHER, M. D.

Assistant Attending Physician for Contagious Diseases
CHARLES K. WINNE, M. D.

Assistant Attending Surgeons
ALVAH H. TRAVER, M. D.
WM. D. ALLEN, M. D.
J. LEWI DONHAUSER, M. D.

Assistant Attending Gynecologist
TIFFANY LAWYER, M. D.

Assistant Attending Laryngologist
WM. G. KEENS, M. D.

Assistant Attending Ophthalmologist and Otologist
CHARLES H. MOORE, M. D.

Resident Physicians and Surgeons

ARTHUR M. DICKINSON, M. D. Chief Resident Surgeon
HERBERT A. VOGEL, M. D. Chief Resident Physician
SAMUEL W. GREEN, M. D.
JOHN L. HEMSTEAD, M. D.
HAROLD A. PECK, M. D.
ABRAHAM RABINER, M. D.
EDWARD BERNARD O'KEEFE, M. D.

Dispensary Physicians and Surgeons

CLARENCE F. GRAHAM, M. D.
J. LEWI BENDELL, M. D.
WM. P. HOWARD, M. D.
J. MONTGOMERY MOSHER, M. D.
TIFFANY LAWYER, M. D.
WM. G. KEENS, M. D.
CHARLES H. MOORE, M. D.
JOSEPH A. LANAHAN, M. D.
G. EMORY LOCHNER, M. D.
JOHN E. HESLIN, M. D.